suspected. Strict precautions should be employed during invasive procedures even in patients not suspected of being at high risk of HIV infection.

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Carcinoma of the gall bladder – can we do anything?

Sir,

Chattopadhyay et al.1 concluded that the diagnosis of gall bladder carcinoma was clinical in the majority of cases and the investigations merely confirmatory. We would like to report a case where repeated investigations simply delayed a diagnosis which was eventually made by laparotomy.

A 72 year old female was admitted with a short history of anorexia, nausea, vomiting, weight loss and back pain with urinary frequency. On examination she was pyrexial 38.4°C, icteric and had hepatomegaly with a tender right lumbar mass. Liver function tests showed an obstructive picture and urinalysis showed evidence of infection.

Clinically it was thought she had a pancreatic carcinoma and possibly a right pyonephrosis. The ultrasound scan suggested a 5 cm mass in the head of the pancreas and a dilated common bile duct, a thick walled gall bladder containing several calculi, a right hydrenephrosis and a suspicion of metastases in the right lobe of the liver. Endoscopic retrograde cholangiopancreatogram (ERCP), performed at another hospital, showed multiple stones in the common bile duct some of which were extracted after sphincterotomy. Arrangements were made for repeat ERCP in 4 weeks.

The patient had improved both clinically and biochemically. Because of the strong suspicion of malignancy the ultrasound scan was repeated. This time it failed to show any pancreatic mass, but the report was otherwise similar to the first. An outpatient computed tomographic (CT) scan showed generalized pancreatic atrophy, gas in the biliary tree and a right hydrenephrosis. Two weeks later the patient deteriorated and an exploratory laparotomy was performed. This revealed an intrahepatic malignant gall bladder infiltrating the liver in addition to stones in the common bile duct. Gall bladder and liver biopsy confirmed an undifferentiated large cell carcinoma infiltrating into liver tissue. The patient died 9 days postoperatively with bronchopneumonia.

Our patient had endured 6 weeks of tests involving 2 ultrasounds, 1 ERCP and sphincterotomy, 1 CT scan and was awaiting a repeat ERCP when her diagnosis was made by laparotomy. The estimated cost of these tests would be over £1000.

We feel this case highlights some of the problems of modern technology where tests are performed one after another to try and establish a precise ‘medical’ diagnosis, when a simple good old fashioned laparotomy will very quickly establish the diagnosis and modern clinicians should not forget this very basic fact.

With reference to gall bladder carcinoma in particular, there is a very low preoperative diagnosis of 5–8.6%2,3 with a correspondingly poor prognosis. Ultrasound scans claim diagnostic successes of 88–100%4,5 for early detection. ERCP is acclaimed by some,6 CT scans by others.7 Driglich infusion cholangiography, percutaneous transhepatic cholangiography and coeliac axis angiography are also considered contributory. Gall stones coexist in 54–75% of cases, and interpretation of the diagnostic features becomes difficult and unreliable.3,8 The list of investigations grows longer and longer as does the costs and time taken to do them. A ‘simple old fashioned’ laparotomy remains the quickest and most reliable ‘test’.

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